Beaumont

Request for Application

BeaumontCredentialing@beaumont.org

Beaumont Health
Central Credentialing / Medical Staff Services
26901 Beaumont Blvd.
Southfield, MI 48033
947-522-2001

A valid Michigan state license, liability insurance (with limits of $100K, $300K), a Michigan controlled substance license (if applicable), and DEA (if applicable) are required for all practitioners applying to Beaumont Health.

Practitioner Name: _____ Degree: _____
(Last / First / Middle Initial)

Date of Birth: ____/____/____ Last 4 digits of Social Security: _____ NPI#_____

Practicing Specialty: _____

Do you have an active Michigan state license? ☐ Yes ☐ No ☐ Applied ☐ Not applicable

Do you have an active Michigan controlled substance license? ☐ Yes ☐ No ☐ Applied ☐ Not applicable

Do you have an active DEA? ☐ Yes ☐ No ☐ Applied ☐ Not applicable

Supervising Physician (for Advance Practice Providers ONLY):_____

Beaumont Hospitals Applying To (select all that apply)

☐ Dearborn ☐ Farmington Hills ☐ Grosse Pointe ☐ Royal Oak ☐ Taylor ☐ Trenton ☐ Troy ☐ Wayne

If selecting more than one hospital, which location will be your primary? _____

Will you be employed by Beaumont Health? Yes ☐ No ☐

If yes, please indicate anticipated start date with organization: _____

Do you need inpatient privileges once on staff? Yes ☐ No ☐

Do you plan to establish, or have you established an office near the hospital(s) applying at? Yes ☐ No ☐

Email address where to send application: _____

Primary phone number to reach you if questions: _____

Office Information

Name of Practice:_____

Primary Office Address: _____
(Street / City / State / Zip Code)

Office Telephone: _____ Office Fax: _____

Anticipated Start Date with Practice: _____

Is this a: ☐ Group Practice ☐ Solo Practice ☐ Hospitalist Will you be a moonlighter/house physician: Yes ☐ No ☐

Are you in a current residency or fellowship program? Yes ☐ No ☐

If yes, what is expected date of completion?_____ If no, please indicate date program was completed:_____

Are you board certified in practicing specialty? Yes ☐ No ☐

Name of certifying board: _____

Certification date: _____ Expiration date: _____

If not board certified, what is your status in the certification process: _____

Have you ever taken and failed a certification exam? Yes ☐ No ☐

If yes, please explain: _____

All application fees are non-refundable:

Application fees are due upon submission of application: Physician Initial Hospital fee is $350, APP Initial Hospital fee is $250. Physician/APP fee for each additional hospital is $200 to which you are applying if requested at time of initial request. Future request(s) for application(s) will be charged as outlined above. (Payment not required with this request).

I request an application for appointment to Beaumont Health. I understand that completing this Request for Application in no way obligates the organization and/or medical staff(s) to afford me medical staff membership and/or privileges.

An application for appointment/privileges shall not be provided to a practitioner, nor will an application be accepted if the practitioner does not meet the minimum requirements for medical staff membership and/or privileges. I understand that the information requested in this document is sought to enable the organization to make an administrative decision as to whether I am eligible to receive an application. I further understand that a determination that I am eligible to receive an application does not give rise to hearing rights under the Medical Staff Bylaws.

I attest that the information provided on this Request for Application is true and accurate to the best of my knowledge and belief.

Practitioner Signature: _____ Date: _____